		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0018275

Facility Name: Alpine Fireside Health Center

Address: 3650 N. Alpine Road (Number) Rockford (City) 61114 (Zip Code)

County: Winnebago

Telephone Number: (815) 877-7408 **Fax #** (815) 877-9818

IDPA ID Number: 362753251001

Date of Initial License for Current Owners: 1973

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[x]	PROPRIETARY	[ ]	GOVERNMENTAL		
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State		
[ ]	Trust	[ ]	Partnership	[ ]	County		
IRS Exemption Code		[ ]	Corporation	[ ]	Other		
		[x]	"Sub-S" Corp.				
		[ ]	Limited Liability Co.				
		[ ]	Trust				
		[ ]	Other				

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/2000 to 9/30/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 8/7/2001

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	63	22,995	3
4		Intermediate/DD			4
5	64	Sheltered Care (SC)	31	21,545	5
6		ICF/DD 16 or Less			6
7	127	TOTALS	94	44,540	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	8,663	6,721		15,384	10
11	ICF/DD					11
12	SC		8,278		8,278	12
13	DD 16 OR LESS					13
14	TOTALS	8,663	14,999		23,662	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 53.13%

D. How many bed-hold days during this year were paid by Public Aid?
36 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1973

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided 0

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/2001 Fiscal Year: 9/30/2001

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	184,138	7,811	5,104	197,053		197,053		197,053			1
2	Food Purchase		146,898		146,898		146,898	(1,305)	145,593			2
3	Housekeeping	40,540	15,112		55,652		55,652		55,652			3
4	Laundry	22,062	2,021	8,741	32,824		32,824		32,824			4
5	Heat and Other Utilities			79,474	79,474		79,474	26	79,500			5
6	Maintenance	53,536	26,765	18,025	98,326		98,326		98,326			6
7	Other (specify):*											7
8	**TOTAL General Services**	300,276	198,607	111,344	610,227		610,227	(1,279)	608,948			8
	B. Health Care and Programs											
9	Medical Director			10,500	10,500		10,500		10,500			9
10	Nursing and Medical Records	845,841	33,663	3,546	883,050		883,050		883,050			10
10a	Therapy											10a
11	Activities	53,068	1,970	6,654	61,692		61,692	(81)	61,611			11
12	Social Services	23,443		5,899	29,342		29,342		29,342			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	922,352	35,633	26,599	984,584		984,584	(81)	984,503			16
	C. General Administration											
17	Administrative	95,393			95,393		95,393		95,393			17
18	Directors Fees											18
19	Professional Services			104,231	104,231		104,231	(8,445)	95,786			19
20	Dues, Fees, Subscriptions & Promotions			21,642	21,642		21,642	(1,901)	19,741			20
21	Clerical & General Office Expenses	65,278	7,183	22,208	94,669		94,669	88	94,757			21
22	Employee Benefits & Payroll Taxes			245,264	245,264		245,264		245,264			22
23	Inservice Training & Education			451	451		451		451			23
24	Travel and Seminar			7,011	7,011		7,011	971	7,982			24
25	Other Admin. Staff Transportation			7,963	7,963		7,963		7,963			25
26	Insurance-Prop.Liab.Malpractice			16,820	16,820		16,820		16,820			26
27	Other (specify):*											27
28	**TOTAL General Administration**	160,671	7,183	425,590	593,444		593,444	(9,287)	584,157			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,383,299	241,423	563,533	2,188,255		2,188,255	(10,647)	2,177,608			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Alpine Fireside Health Center, Ltd.
Provider Number: 0018275
9/30/2001

PG 3, Line 25 detail (Acc# 8920)

City of Rockford - City Sticker	$	117
AAA Financial	$	4,088
LLOYDS	$	1,456
Ketut Getiawan	$	26
Delap Oil & Gas	$	85
Maaco	$	1,383
Misc.	$	808
	$	7,963

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center #0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			2,340	2,340		2,340	82,740	85,080			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			10,140	10,140		10,140	69,245	79,385			32
33	Real Estate Taxes			51,992	51,992		51,992		51,992			33
34	Rent-Facility & Grounds			448,497	448,497		448,497	(448,497)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			512,969	512,969		512,969	(296,512)	216,457			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		2,503		2,503		2,503		2,503			39
40	Barber and Beauty Shops			11,265	11,265		11,265		11,265			40
41	Coffee and Gift Shops			147	147		147		147			41
42	Provider Participation Fee			34,493	34,493		34,493		34,493			42
43	Other (specify):* Nonallowable costs			55,877	55,877		55,877	(55,877)				43
44	**TOTAL Special Cost Centers**		2,503	101,782	104,285		104,285	(55,877)	48,408			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,383,299	243,926	1,178,284	2,805,509		2,805,509	(363,036)	2,442,473			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,305)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,307)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(222)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(20)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(32,844)			24
25	Fund Raising, Advertising and Promotional	(26,570)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see Sched. 5A	(7,176)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,444)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(293,592)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (293,592)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (363,036)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Health Center

ID# 0018275

Report Period Beginning: 10/1/2000

Ending: 9/30/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Alpine Fireside Healthcare, Ltd.
Provider # 0018275
9/30/2001

Schedule 5A

VI. Adjustment Detail, Line 29

Non-Allowable Expenses	Amount	Line
Activity Income Offset	(81)	11
Out-of-Period Legal Fees	(8,445)	19
Miscellaneous Income Offset	(528)	21
Miscellaneous Dues Disallowed	(1,901)	20
Non-Allowable Taxes	3,779	43
Total	(7,176)	

See Accountants' Compilation Report.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,305)	0	0	0	0	0	0	0	0	0	0	(1,305)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	26	0	0	0	0	0	0	0	0	0	26	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,305)	26	0	0	0	0	0	0	0	0	0	(1,279)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	616	0	0	0	0	0	0	0	0	0	616	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	971	0	0	0	0	0	0	0	0	0	971	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	1,587	0	0	0	0	0	0	0	0	0	1,587	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,305)	1,613	0	0	0	0	0	0	0	0	0	308	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alpine Fireside Health Center # 0018275 **Report Period Beginning:** 10/1/2000 **Ending:** 9/30/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	82,740	0	0	0	0	0	0	0	0	0	82,740	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,307)	70,552	0	0	0	0	0	0	0	0	0	69,245	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(448,497)	0	0	0	0	0	0	0	0	0	(448,497)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,307)	(295,205)	0	0	0	0	0	0	0	0	0	(296,512)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(26,812)	0	0	0	0	0	0	0	0	0	0	(26,812)	43
44	**TOTAL Special Cost Centers**	(26,812)	0	0	0	0	0	0	0	0	0	0	(26,812)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(29,424)	(293,592)	0	0	0	0	0	0	0	0	0	(323,016)	45

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Johs Oksnevad	100			Johs Oksnevad	Rockford, IL	Real Estate Lessor

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	5	Utilities		Johs Oksnevad	100.00%	26	26	2
3	V	21	Office		Johs Oksnevad	100.00%	616	616	3
4	V	24	Travel and Seminar		Johs Oksnevad	100.00%	971	971	4
5	V	30	Depreciation		Johs Oksnevad	100.00%	82,740	82,740	5
6	V	32	Interest		Johs Oksnevad	100.00%	70,552	70,552	6
7	V	34	Rent-Facility & Grounds	448,497	Johs Oksnevad	100.00%		(448,497)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 448,497			$ 154,905	$ * (293,592)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Johs Oksnevad	President	Asst. Adminstr.	100.00	0	20	50.00	Salary	$ 25,000	L17, C1	1
2	Gordon Oksnevad	Administrator	Administrator	0.00	0	40+	100.00	Salary	70,393	L17, C1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 95,393		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Amcore Bank		X	Improvements & work capital	$9,479.10	5/99	$ 1,000,000	$ 917,226	2013	0.0775	$ 70,552	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Johs Oksnevad	X		Working Capital	none	9/30/99	169,000	194,380	Demand	0.0600	10,140	6
7												7
8												8
9	TOTAL Facility Related				$9,479.10		$ 1,169,000	$ 1,111,606			$ 80,692	9
	B. Non-Facility Related*											
10												10
11												11
12									Offset Interest Income		(1,307)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (1,307)	14
15	TOTALS (line 9+line14)						$ 1,169,000	$ 1,111,606			$ 79,385	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.		$ 36,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$ 48,992	2
3. Under or (over) accrual (line 2 minus line 1).		$ 12,992	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 39,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 51,992	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	41,270	8
	1997	43,957	9
	1998	45,628	10
	1999	46,107	11
	2000	48,992	12

Accrual Calculation:			
2000 Tax bill	48,992	2000 bill	48,992
% Increase	1.05%		
Estimated 2001 Taxes	51,638 x 9/12 = 38,728.18	use 39,000	

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alpine Fireside Health Cente COUNTY Winnebago

FACILITY IDPH LICENSE NUMBER 0018275

CONTACT PERSON REGARDING THIS REPORT Gordon Oksnevad

TELEPHONE 815-877-7408 FAX #: 815-877-9818

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	12-05-376-003	Nursing home	$ 48,992.16	$ 48,992.16
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 48,992.16	$ 48,992.16

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,000 B. General Construction Type: Exterior Brick Frame Concrete/Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	2.8 acres	1961	$ 10,000	1
2					2
3	TOTALS	2.8 acres		$ 10,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	127		1973	1973	$ 717,727	$	30	$ 7,559	$ 7,559	$ 717,727	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9				1973	1,277		10			1,277	9
10				1973	3,172		20			3,172	10
11				1973	694		40	17	17	493	11
12				1973	201		25			201	12
13				1973	93,791		11			93,791	13
14				1973	96,886		34	2,850	2,850	67,972	14
15				1974	8,366		11			8,366	15
16				1975	3,593		10			3,593	16
17				1977	10,055		10			10,055	17
18				1981	2,656		15			2,656	18
19				1982	5,132		11			5,132	19
20				1982	1,063		15			1,063	20
21				1984	21,939		15			21,939	21
22	Smoke detectors			1984	1,145		10			1,145	22
23				1985	3,300		15			3,300	23
24	Roof			1986	19,094		15	636	636	19,094	24
25	Kitchen addition & storm sewers			1988	235,818		20	11,791	11,791	159,178	25
26	Kitchen improvements			1989	9,541		20	477	477	6,201	26
27	Black top			1990	5,000		10			5,000	27
28	Broiler			1991	29,033		20	1,452	1,452	15,246	28
29	Lawn sprinkler			1992	5,000		15	333	333	2,998	29
30	Leasehold improvements			1993	13,972		15	931	931	7,914	30
31	Roof improvements			1994	57,648		15	3,843	3,843	29,001	31
32	Generator			1995	34,924		15	2,328	2,328	15,132	32
33	Air Conditioning System			1999	280,820		15	18,721	18,721	46,803	33
34	Carpeting/Flooring/Wall Covering			1999	81,812		15	5,454	5,454	13,635	34
35	Parking Lot Lights			1999	16,900		15	1,126	1,126	2,815	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Air Conditioning	2000	$ 24,655	$	15	$ 822	$ 822	$ 822	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,785,214	$		$ 58,340	$ 58,340	$ 1,265,721	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 223,117	$ 1,677	$ 11,097	$ 9,420	3-10 yrs	$ 221,256	71
72	Current Year Purchases							72
73	Fully Depreciated Assets	303,476					303,476	73
74								74
75	TOTALS	$ 526,593	$ 1,677	$ 11,097	$ 9,420		$ 524,732	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Administrator	1995 Nissan Sentra	1998	$ 6,630	$ 663	$ 663	$	5	$ 4,641	76
77	Maintenance Truck	1988 GMC Truck	1990	9,700				5	9,700	77
78	Patient Transportation	1998 Chevy Venture M/V	1999	25,654		5,131	5,131	5	12,827	78
79	Patient Transportation	1998 Ford Supreme Bus	1999	49,247		9,849	9,849	5	24,623	79
80	TOTALS			$ 91,231	$ 663	$ 15,643	$ 14,980		$ 51,791	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,413,038	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 2,340	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 85,080	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 82,740	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,842,244	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES [X] NO
   It is the policy of this facility to only hire certified nurses aides
   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				2,503		2,503	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 2,503		$ 2,503	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance of $30,000)	128,841	128,841	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	19,655	19,655	6
7	Other Prepaid Expenses	17,923	17,923	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 166,419	$ 166,419	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		10,000	13
14	Buildings, at Historical Cost		1,785,214	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	109,159	617,824	16
17	Accumulated Depreciation (book methods)	(105,309)	(1,842,244)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,850	$ 570,794	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 170,269	$ 737,213	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 110,007	$ 110,008	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	194,380	194,380	29
30	Accrued Salaries Payable	48,906	48,906	30
31	Accrued Taxes Payable (excluding real estate taxes)	28,123	28,123	31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,000	39,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	1,685	1,685	35
	Other Current Liabilities(specify):			
36	Accrued Rent	1,168,654	1,168,654	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,590,755	$ 1,590,756	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		917,226	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 917,226	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,590,755	$ 2,507,982	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,420,486)	$ (1,770,769)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 170,269	$ 737,213	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (883,727)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (883,727)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(536,759)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (536,759)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,420,486)	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,233,337	1
2	Discounts and Allowances for all Levels	(640)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,232,697	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	20,229	13
14	Non-Patient Meals	1,305	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	88	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 21,622	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,307	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,307	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule 19A**	13,124	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 13,124	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,268,750	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	610,227	31
32	Health Care	984,584	32
33	General Administration	593,444	33
	B. Capital Expense		
34	Ownership	512,969	34
	C. Ancillary Expense		
35	Special Cost Centers	69,792	35
36	Provider Participation Fee	34,493	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,805,509	40
41	**Income before Income Taxes (line 30 minus line 40)****	(536,759)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (536,759)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Tax return is filed on a cash basis.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Alpine Fireside Healthcare, LTD.
Provider # 0018275
9/30/2001

Schedule 19A

XVII. Income Statement
Line 28A

Revenue	Amount
Private Bed Hold Days	8,409
Activities & Outings Income	81
Store & Misc. Sales	4,272
Misc. Income	362
Total	13,124

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 50,032	$ 24.05	1
2	Assistant Director of Nursing	1,608	1,710	37,284	21.80	2
3	Registered Nurses	4,674	4,886	96,528	19.76	3
4	Licensed Practical Nurses	14,983	15,533	251,043	16.16	4
5	Nurse Aides & Orderlies	38,522	42,409	410,954	9.69	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	846	893	9,066	10.15	9
10	Activity Assistants	5,293	5,642	44,002	7.80	10
11	Social Service Workers	2,188	2,278	23,443	10.29	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	37,529	18.04	13
14	Head Cook	10,417	10,693	73,094	6.84	14
15	Cook Helpers/Assistants	10,413	10,568	73,515	6.96	15
16	Dishwashers					16
17	Maintenance Workers	4,083	4,339	53,536	12.34	17
18	Housekeepers	6,145	6,311	40,540	6.42	18
19	Laundry	2,293	2,371	22,062	9.30	19
20	Administrator	2,080	2,080	70,393	33.84	20
21	Assistant Administrator	1,040	1,040	25,000	24.04	21
22	Other Administrative					22
23	Office Manager	1,969	2,071	27,541	13.30	23
24	Clerical	3,361	3,402	37,737	11.09	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	114,075	120,386	$ 1,383,299 *	$ 11.49	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	103	$ 5,104	L1, C3	35
36	Medical Director	Monthly	10,500	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	812	1,931	L10. C. 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	266	6,654	L11. C. 3	44
45	Social Service Consultant	236	5,899	L12. C.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,417	$ 30,088		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	73	1,615	l. 10 c. 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	73	$ 1,615		53

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Johs Oksnevad	Asst. Adminstr.	100%	$ 25,000
Gordon Oksnevad	Administrator	0%	70,393
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,393

B. Administrative - Other

Description	Amount
N/A	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Williams & McCarthy	Legal	$ 525
Duane, Morris & Heckscher LLP	Legal	39,337
American Express Tax & Bus. Svc.	Accounting	20,281
Altschuler, Melvoin		
and Glasser LLP	Accounting	13,524
R.E. Harrington	U/C Consulting	300
Care Computer Systems	Computer Consulting	6,263
Business Management	Computer Consulting	1,280
Keane Care, Inc	Computer Consulting	17,647
AAA Financial	Computer Consulting	4,842
Advanced Copy System	Computer Consulting	232
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 104,231

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,087
Unemployment Compensation Insurance	29,969
FICA Taxes	101,440
Employee Health Insurance	55,027
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pre-employment Physicals	11,103
Uniforms	1,638
TOTAL (agree to Schedule V, line 22, col.8)	$ 245,264

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,200
Health Care Worker Background Check	
(Indicate # of checks performed 123)	1,480
Miscellaneous Licenses	830
Illinois Health Care Assoc. Dues	5,714
NFIS	600
Misc. subscriptions	1,917
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,741

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,644
Seminar Expense	6,338
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,982

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Alpine Fireside Healthcare, LTD.
Provider # 0018275
9/30/2001

Schedule 21A

C. Professional Services

Total from page 21, part C	104,231
Less: Out-of-period legal fees	
Duane, Morris & Heckscher	(8,445)
Corrected Total	95,786

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 Report Period Beginning: 10/1/2000 Ending: 9/30/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Alpine Fireside Health Center # 0018275 **Report Period Beginning:** 10/1/2000 **Ending:** 9/30/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $5,714**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **N/A**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **4,613** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **34,493**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **1,305**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records are maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

		Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary		184,138	7,811	5,104	197,053	0	197,053	0	197,053
2. Food Purchase		0	146,898	0	146,898	0	146,898	-1,305	145,593
3. Housekeeping		40,540	15,112	0	55,652	0	55,652	0	55,652
4. Laundry		22,062	2,021	8,741	32,824	0	32,824	0	32,824
5. Heat and Other Utilities		0	0	79,474	79,474	0	79,474	26	79,500
6. Maintenance		53,536	26,765	18,025	98,326	0	98,326	0	98,326
7. Other (specify)*		0	0	0	0	0	0	0	0
8. Total General Services		300,276	198,607	111,344	610,227	0	610,227	-1,279	608,948
9. Medical Director		0	0	10,500	10,500	0	10,500	0	10,500
10. Nursing & Medical Records		845,841	33,663	3,546	883,050	0	883,050	0	883,050
10a. Therapy		0	0	0	0	0	0	0	0
11. Activities		53,068	1,970	6,654	61,692	0	61,692	-81	61,611
12. Social Services		23,443	0	5,899	29,342	0	29,342	0	29,342
13. Nurse Aide Training		0	0	0	0	0	0	0	0
14. Program Transportation		0	0	0	0	0	0	0	0
15. Other (specify)*		0	0	0	0	0	0	0	0
16. Total Health Care & Programs		922,352	35,633	26,599	984,584	0	984,584	-81	984,503
17. Administrative		95,393	0	0	95,393	0	95,393	0	95,393
18. Directors Fees		0	0	0	0	0	0	0	0
19. Professional Services		0	0	104,231	104,231	0	104,231	-8,445	95,786
20. Fees, Subscriptions & Promotion		0	0	21,642	21,642	0	21,642	-1,901	19,741
21. Clerical & General Office		65,278	7,183	22,208	94,669	0	94,669	88	94,757
22. Employee Benefits & Payroll		0	0	245,264	245,264	0	245,264	0	245,264
23. Inservice Training & Education		0	0	451	451	0	451	0	451
24. Travel and Seminar		0	0	7,011	7,011	0	7,011	971	7,982
25. Other Admin. Staff Trans		0	0	7,963	7,963	0	7,963	0	7,963
26. Insurance-Prop.Liab.Malpractice		0	0	16,820	16,820	0	16,820	0	16,820
27. Other (specify)*		0	0	0	0	0	0	0	0
28. Total General Adminis		160,671	7,183	425,590	593,444	0	593,444	-9,287	584,157
29. Total General Administrative		1,383,299	241,423	563,533	2,188,255	0	2,188,255	-10,647	2,177,608
30. Depreciation		0	0	2,340	2,340	0	2,340	82,740	85,080
31. Amortization of Pre-Op. & Org.		0	0	0	0	0	0	0	0
32. Interest		0	0	10,140	10,140	0	10,140	69,245	79,385
33. Real Estate		0	0	51,992	51,992	0	51,992	0	51,992
34. Rent - Facility & Grounds		0	0	448,497	448,497	0	448,497	-448,497	0
35. Rent - Equipment & Vehicles		0	0	0	0	0	0	0	0
36. Other (specify):*		0	0	0	0	0	0	0	0
37. Total Ownership		0	0	512,969	512,969	0	512,969	-296,512	216,457
38. Medically Necessary T		0	0	0	0	0	0	0	0
39. Ancillary Service Cent		0	2,503	0	2,503	0	2,503	0	2,503
40. Barber and Beauty Shop		0	0	11,265	11,265	0	11,265	0	11,265
41. Coffee and Gift Shops		0	0	147	147	0	147	0	147
	42	0	0	34,493	34,493	0	34,493	0	34,493
43. Other (specify):*		0	0	55,877	55,877	0	55,877	-55,877	0
44. Total Special Cost Ce		0	2,503	101,782	104,285	0	104,285	-55,877	48,408
45. Grand Total		1,383,299	243,926	1,178,284	2,805,509	0	2,805,509	-363,036	2,442,473

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	-100,774	-100,774
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	128,841	128,841
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	19,655	19,655
7. Other Prepaid Expenses	17,923	17,923
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	65,645	65,645
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	10,000
14. Buildings, at Historical Cost	0	1,785,214
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	109,159	617,824
17. Accumulated Depreciation (book methods)	-105,309	-1,842,244
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	3,850	570,794
25. Total Assets	69,495	636,439
CURRENT LIABILITIES		
26. Accounts Payable	9,234	9,234
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	194,380	194,380
30. Accrued Salaries Payable	48,906	48,906
31. Accrued Taxes Payable	28,123	28,123
32. Accrued Real Estate Taxes	39,000	39,000
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	1,685	1,685
36. Other Current Liabilities (specify):	1,168,654	1,168,654
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	1,489,982	1,489,982
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	917,226
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	917,226
46.Total Liabilities	1,489,982	2,407,208
47.Total Equity	-1,420,487	-1,770,769
48.Total Liabilities and Equity	69,495	636,439

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,233,337
2. Discounts and Allowances for all Levels	-640
Subtotal - Inpatient Care	2,232,697
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	0
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	20,229
14. Non-Patient Meals	1,305
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	88
Subtotal - Other Operating Revenue	21,622
24. Contributions	0
25. Interest and Other Investments Income	1,307
Subtotal - Non-Operating Revenue	1,307
27. Other Revenue (specify):	13,124
28. Other Revenue (specify):	0
Subtotal - Other Revenue	13,124
30. Total Revenue	2,268,750
31. General Services	610,227
32. Health Care	984,584
33. General Administration	593,444
34. Ownership	512,969
35. Special Cost Centers	69,792
35. Provider Participation Fee	34,493
37. Other	0
40. Total Expenses	2,805,509
41. Income Before Income Taxes	-536,759
42. Income Taxes	0
43. Net Income or Loss for the Year	-536,759
32. Health Care	984,584
33. General Administration	593,444
34. Ownership	512,969
35. Special Cost Centers	69,792
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40. Total Expenses	2,805,509
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42. Income Taxes	0
43. Net Income or Loss for the Year	-536,759

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Alpine Fireside Health C** **01:54 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-363,036	equal to	-363,036	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	79,385	equal to	79,385	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	51,992	equal to	51,992	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	85,080	equal to	85,080	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	0	equal to	0	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	2,503	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	610,227	equal to	610,227	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	984,584	equal to	984,584	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	593,444	equal to	593,444	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	512,969	equal to	512,969	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	69,792	equal to	69,792	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	34,493	equal to	34,493	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	845,841	equal to	845,841	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	53,068	equal to	53,068	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	23,443	equal to	23,443	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	184,138	equal to	184,138	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	53,536	equal to	53,536	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	40,540	equal to	40,540	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	22,062	equal to	22,062	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	95,393	equal to	95,393	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	65,278	equal to	65,278	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,383,299	equal to	1,383,299	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,104	< or = to	5,104	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	10,500	< or = to	10,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	3,546	< or = to	3,546	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	6,654	< or = to	6,654	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	5,899	< or = to	5,899	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	95,393	equal to	95,393	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	104,231	equal to	104,231	0	FAILED	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	245,264	equal to	245,264	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	19,741	equal to	19,741	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	7,982	equal to	7,982	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	34,493	equal to	34,493	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	0	equal to	0	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-293,592	equal to	-293,592	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,111,606	equal to	1,111,606	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	39,000	equal to	39,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	10,000	equal to	10,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,785,214	equal to	1,785,214	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	617,824	equal to	617,824	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,842,244	equal to	1,842,244	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-1,420,486	equal to	-1,420,486	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-536,759	equal to	-536,759	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	170,269	equal to	170,269	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1